Behavioral Health Integration Compendium

PRESENTED BY THE BHI COLLABORATIVE
This Compendium was developed based on the generous contributions of time and expertise by the following BHI Collaborative members:

A special thanks to BHI Collaborative member, American College of Obstetricians and Gynecologists, for their additional insights and feedback.

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BEHAVIORAL HEALTH INTEGRATION COMPENDIUM

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Part 1: Welcome to the Behavioral Health Integration Compendium

This Compendium has been developed by the Behavioral Health Integration (BHI) Collaborative, led by several of the nation’s leading physician organizations, as a tool for physicians and their practices to learn about and implement behavioral health integration (BHI) in order to achieve the goal of optimal whole person care.
Our aim is to provide accessible, detailed information on the steps required to integrate behavioral health care, which includes mental health and substance use disorders (SUD), into your practice and to provide links to resources should you desire further, more specific information.

This Compendium condenses a wide range of carefully vetted existing resources and is intended to provide helpful frameworks and actionable information to effectively implement behavioral health (BH) care. It will be updated as new content becomes available, ensuring the most current, relevant information is available for your use. As you use the Compendium in your practice, we encourage you to share your stories about your experience using it and to point us to additional resources that might be included or mentioned in future editions. We welcome your suggestions on what additional information should be featured in future iterations. You may contact us at Practice.Sustainability@ama-assn.org. If you are interested in learning more about our BHI Collaborative initiatives, you can find more resources at the Collaborative’s website.

A note about using the BHI Compendium

Different pathways may be taken to integrate behavioral health into primary care, pediatrics, obstetrics and gynecology, or other specialty care. The Collaborative recognizes the importance of meeting practices wherever you are on your journey to integration and providing relevant tools for success as you go forward. Integration is a continuous process and not a time-limited project. There are many ways to pursue BHI and endless opportunities to modify such efforts as patient needs and practice resources evolve.

This document is intended to provide relevant foundational information and resources so you and your practice have what you need to make the best decisions for your practice and patients.
WHAT IS BEHAVIORAL HEALTH (BH)?

Throughout this Compendium, behavioral health (BH) will refer to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral health care will refer to the prevention, diagnosis, and treatment of those conditions.

WHAT IS BEHAVIORAL HEALTH INTEGRATION (BHI)?

BHI is widely accepted as the result of primary care (or other care settings) and behavioral physicians and other clinicians, working together with patients and families, using a systematic approach to provide patient-centered care.

Mental health disorders also impact approximately one in five of America’s youth, which can cause significant challenges at home, school, and/or in their community. However, only 10% of U.S. children and adolescents ages 3 to 17 receive any treatment or counseling from a mental health professional. Further, psychiatric disorders impacting children and adolescents are estimated to have an annual treatment cost of around $40 billion.

Dedicated high-quality research focused on the design, implementation, and outcomes of various models of integrated health care have shown that BHI is integral to achieving the Quadruple Aim:

- Improved patient experience
- Improved population health
- Reduced costs
- Improved care team well-being

Why is BHI important?

One in five adults is living with a significant mental health or substance use disorder.

Additionally, one in eight women report symptoms of depression after giving birth. Stigma, system fragmentation, and shortages in BH clinical resources and qualified mental health professionals have resulted in a substantial mismatch between the prevalence of these conditions and the proportion of individuals who receive effective treatment. One of the most effective solutions for closing the gap between need and access is behavioral health integration (BHI) into primary care.

There are many specific benefits to incorporating behavioral health services into primary and specialty care, including but not limited to:

- **Promoting overall health:** Integrating behavioral health into primary care acknowledges the importance of physical and mental health to whole person health.
- **Promoting long-term value:** Treating behavioral health issues in primary care settings is cost-effective in the long term.
- **Closing treatment gaps:** Coordinating physical and behavioral health care helps close the gap between the prevalence of these issues and the number of people receiving treatment.
- **Enhancing access:** Aside from providing greater access to long-term monitoring and management to individuals affected, services can often be accessed more easily when behavioral health is integrated into primary care.
- **Improving patient satisfaction:** Integrated care is more convenient for the patient. It also more effectively addresses their entire well-being, which leads to a sense of higher-quality care and greater satisfaction.
- **Increasing positive outcomes:** The majority of patients with behavioral health issues treated in an integrated primary care setting exhibit positive health outcomes, particularly when they are connected to a network of services at a specialty care level in their community.
- **Reducing stigma:** Delivery of behavioral health services in a primary care setting may reduce the reluctance some individuals feel about seeking care at a facility that delivers only behavioral health services. Community outreach, care coordination, and mental health promotion by organizations that promote total patient care can reduce stigma and discrimination.
- **Reducing risk of self-harm and suicide:** Caring for patients’ behavioral health plays an important role in diagnosing and treating self-harm and suicidal ideation, preventing one of the top causes of death (suicide) in the United States.
There are many ways to approach BHI, and practices have a number of models to choose from. Many practices have taken a hybrid approach, implementing elements from available models of care and picking and choosing based on the needs of their patient population and the resources available in their community. What's possible and what works in a large, urban setting may not be feasible in a rural or frontier setting. One size does not fit all.

**TIP:**
This chapter describes the basic elements of the most common models of care, which can be implemented “as is,” or in a combination, as most appropriate for your specific practice’s needs.

**BHI: IDEAL PATIENT POPULATIONS**

BHI has been shown to be most beneficial to patients with mild-to-moderate depression and/or anxiety as well as those receiving treatment for substance use disorders in the primary care setting. In pediatrics, BHI has been widely used to help address a large number of behavioral issues, such as parent-child conflicts and attentional and organizational issues. Integration of behavioral health care within primary care can also be effective for patients with chronic health conditions such as obesity, diabetes, hypertension, or chronic pain (with or without a substance use disorder).

**WATCH-OUT:**
BHI models of care are not meant to meet the needs of patients with complex mental health issues (e.g., bipolar disease, schizophrenia, unstable psychosis, etc.) or those who require urgent referral for psychiatric care and/or inpatient behavioral care (e.g., substance withdrawal or detoxification, suicidal ideation, violent or destructive behavior). Practices implementing BHI should have protocols in place for referral or transfer to a higher level of care when urgent or life-threatening conditions and needs are identified.
Integrated Care Spectrum

While BHI can take many forms, care can be delivered along a spectrum from coordinated to integrated, with six defined levels.

At one end of the spectrum is **coordinated care**, in which clinicians working in different health care settings exchange information about shared patients to facilitate care. The key element here is communication.

In the middle of the BHI spectrum is **co-location**, in which the behavioral health specialist is physically located in a primary care clinic, or the primary care physician or other clinician is physically located in a mental health or substance use disorder treatment setting. The distinguishing feature here is physical proximity.

At the other end of the spectrum is **integrated care**, where the practice team includes primary care and behavioral health physicians and other clinicians working together with patients and families, using a systematic, seamless approach to provide patient-centered care for a defined population. The defining feature here is practice change.

**UNDER COORDINATED CARE ARE LEVELS 1 AND 2:**

**Level 1:**
Minimal Collaboration
Care is delivered in separate facilities with separate systems; communication is infrequent and typically initiated only under compelling circumstances driven by physician and other clinician need; understanding of the others’ roles is limited.

**Level 2:**
Basic Collaboration at a Distance
Behavioral and non-behavioral health clinicians practice in separate facilities with separate systems; periodic communication about shared patients is driven by patient issues; there is appreciation of other physicians’ and other clinicians’ roles as resources.

**LEVELS 3 AND 4 FALL UNDER CO-LOCATION:**

**Level 3:**
Basic Collaboration On-site
Physicians and other clinicians practice in the same facility but not necessarily the same offices. Although they have separate systems, they communicate regularly about shared patients due to the need for each other’s services and referrals.

**Level 4:**
Close Collaboration On-site
Physicians and other clinicians practice in the same facility with some shared systems, such as scheduling and medical records. They collaborate through consultation, co-create coordinated care plans for patients, and interact face-to-face about shared patients on a regular basis.

**LEVELS 5 AND 6 ARE VARIATIONS OF INTEGRATED CARE:**

**Level 5:**
Close Collaboration
Physicians and other clinicians are in the same facility with some shared space and identify delivery system challenges and implement system solutions together. They collaborate via frequent in-person team meetings to discuss patient care and specific patient issues and have an in-depth understanding of others’ roles and culture.

**Level 6:**
Full Collaboration
Physicians and other clinicians are in the same facility and share all practice space, functioning as one integrated team. There is consistent communication at the team and individual levels, and collaboration is due to a shared concept of optimal health care. The roles and cultures of care team members blur or blend together.

**CALLOUT:**
A “warm handoff” can occur either virtually or in-person, when the primary care physician (PCP), medical assistant, or nurse directly introduces the patient to a behavioral health specialist at the time of care. One example of what this might look like is where the medical assistant rooming the patient learns through conversation or screening tools that the patient needs a more in-depth assessment. Paging the behavioral health specialist directly to the room to engage with the patient minimizes the risk that the patient will not receive needed care. A staff member may also schedule a follow-up appointment for the patient, so the responsibility for scheduling that appointment is not placed on the patient.
Selection Criteria for Level of Integration\textsuperscript{xi}

Models of care vary depending on patient population needs and practice capabilities.

The model selected and the elements included are often based on the goals, stage of development, and what is practical at any given time. While this Compendium describes options for providing basic mental health care, some practices may expand their model of care to offer a broader range of behavioral health services.

\textbf{TIP:}

When choosing a model of care, do not allow the process of selecting a model to become a barrier for action. Whatever the initial approach, it can later be modified based on experience.

\begin{flushleft}
\begin{itemize}
\item One of the most common models of care is the Collaborative Care Model (CoCM), as it is evidence-based and employs a cost-effective strategy for treating behavioral health problems in primary care.
\item The cornerstone to CoCM is the implementation of a care team, including a BH care manager who collaborates with the PCP and a consulting psychiatrist. The BH care manager is typically someone with a master’s level education (e.g., MSW and LMSW) or specialized training in behavioral health.
\item In this model, the consulting psychiatrist provides weekly consultation to the primary care practice on a panel of patients, typically those who are not improving. The consulting psychiatrist discusses those patients with the care manager and makes treatment recommendations.
\item Treatment can include focused talking therapies and, when indicated, medication prescribed by the PCP and overseen by the consulting psychiatrist. Patient progress is routinely monitored through the use of screening tools and a practice registry.
\end{itemize}
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\textbf{CALLOUT:}

Many states are developing access programs to provide child psychiatry consultation services to pediatric primary care providers. In addition, this consultation model has also been applied to address maternal depression and related behavioral disorders. For more information, see the Resources section under Introduction to Potential Approaches to BHI.

\textbf{Integrated Models of Care}

Although there are a number of BHI models to choose from, only a few have been the subject of rigorous research demonstrating efficacy.

As a result, these models are better understood and may be viewed more favorably by practices planning to implement BHI:

\begin{itemize}
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\end{itemize}
Integrated Models of Care (Cont.)

While there is more evidence of effectiveness for the CoCM than there is for other models, practices need to start with integration in a way that works best for them.

Alternative models of care may be a better fit for your practice and patient population.

• If your practice has a sizable clinic population that would make implementing the CoCM difficult, the Primary Care Behavioral Health (PCBH) Model, otherwise known as the Behavioral Health Consultant Model, is an alternative to consider.

• In the PCBH Model, the BH consultant, who may be a PsyD, PhD, master’s level clinician, LCSW, or CRNP certified or trained in behavioral health, typically sees an individual patient for a limited time and a limited number of visits. They balance scheduled visits with individual patients while maintaining enough flexibility in their appointment schedule to be available for same-day “warm patient handoffs” or other referrals from the primary care physician and other members of the team.

• If your practice manages persons with substance use disorders or those who are at risk of developing these disorders, Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a public health approach to the delivery of early intervention and treatment.

• SBIRT is an evidence-based approach to improve the care for these individuals and can be used to address other mental and behavioral health conditions as well.

• A clinical encounter, be it in a primary care practice, emergency room, trauma center, or other community setting, is an opportunity to intervene early when an individual is at risk for substance use disorders and before more serious consequences occur.

• Partnerships need to be facilitated to ensure timely access to treatment for referred patients.

Moving Forward:

For more detailed information on the various models of care and how the six levels of integration differ, see the Resources section under Introduction to Potential Approaches to BHI.
Part 3: 
Getting Started
Chapter 4: Making the Case: Establishing the Value of BHI

The Importance and Impact of an Integrated Approach

Practice leadership is a prerequisite to BHI, and without it, integration is unlikely to succeed. Sharing the evidence-based outcomes of BHI with leadership will allow them to see the importance of integration into primary care.
Making the Case

There is increasing evidence and acknowledgment that behavioral health issues are as disabling as cancer or heart disease in terms of lost productivity and premature death.iii

The impact of these illnesses can be substantial and creates a significant burden for the individuals living with them, their families, and the health care system. Issues surrounding behavioral health span all patients regardless of age, sex, gender, race, ethnicity, or socioeconomic status.

According to the Center of Excellence for Integrated Health Solutions, as many as 40% of all patients seen in primary care settings have a mental illness;ii and given that mental and physical health problems are often interwoven, as many as 70% of primary care visits stem from psychosocial issues.iii While patients may initially present with a physical health complaint, data suggests that underlying behavioral health issues are often triggering these visits.iv

Evidence shows that due to lack of financial support, resources, and time in their schedules, care teams are often ill-equipped to fully address the wide range of psychosocial issues presented by their patients. Approximately 67% of patients ages 18 to 54 with behavioral health issues do not receive the care they need.v

The need for integrated care is more evident in the wake of the public health emergency declared in response to the novel coronavirus (COVID-19). The Centers for Disease Control and Prevention released data that found people are experiencing three times the symptoms of anxiety disorder (25.5% vs. 8.1%) and four times the prevalence of depressive disorder (24.3% vs. 6.5%) than those reported in the second quarter of 2019, with racial and ethnic minorities and essential health care workers being more impacted.vi In addition, there was almost a 17.59% increase in suspected overdose submissions when comparing the weeks prior to and following the commencement of state-mandated stay-at-home orders.vii

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Identifying Integration Value

While there is an initial financial investment for integrated care (e.g., additional training time for your team and/or potentially bringing on more staff), implementing BHI is a worthwhile investment in the long term considering the benefits for various stakeholders:

**PHYSICIAN/PRACTICE**
- Increase in work satisfaction and decreased burnout, which brings financial benefits
- Deliver care more efficiently and effectively
- Increase confidence and competence in addressing behavioral health issues
- Connect more efficient care with increased number of patients who can then be billed for services
- Increase in ability to earn pay-for-performance rewards based on reduction costs, patient satisfaction, and improved outcomes

**PATIENTS**
- Establish greater value in complete, comprehensive care, leading to healthier and more satisfied patients
- Greater likelihood to stay at one practice and/or recommend practice to friends and family due to increased satisfaction and symbiotic increase in comfort with raising health concerns with primary care physicians and other clinicians through maintained relationships
- May reduce overall health care costs
- More well equipped to fulfill one’s roles in work, relationships, and other daily activities
- Added support for families and caregivers of patients

**PAYERS**
- Ability to identify and treat patients for behavioral health issues early, leading to lower levels of financial burden down the road
- Reduce emergency room visits, hospital admissions, and intensive care stays

TIP:
Delivering integrated care via telehealth can play a key part in an integrated behavioral health practice. Additionally, this may help to mitigate the impact of uneven distribution and shortages of mental health professionals, particularly in rural areas, and improve access to specialty professionals such as child psychiatrists. For more information on telehealth implementation and services, see the Resources section under Making the Case: Establishing the Value of BHI.
Fair Compensation for Services and Justification for Additional Team Members

Compensation for integrated care, particularly behavioral health services in primary care settings, commonly relies on fee-for-service (FFS) payment; however, there are several ways to review, report, and track the value of behavioral health integration, including:

- **CAPACITY:** Percentage of face-to-face time spent with patients out of the total time available for patient care
- **PRODUCTIVITY:** Count of visits provided
- **PAYMENT:** Average payment for behavioral health services across all payers
- **COST:** Average cost of behavioral health visits across all physicians and other health care professionals

Practice Spotlight

A Case in Successful VBC Implementation

Oak Street Health (OSH), a nationwide system of primary care centers for Medicare-eligible adults, was interested in tracking their success based on sustaining optimal enrollment and positive patient experiences.

Within their value-based care practice model, OSH identified specific metrics to track the fidelity of this model, with the ultimate goal being to optimize actions shown to have the greatest impact on value. The metrics they aligned on included optimal patient enrollment, model effectiveness, universal screening, and repeat screening, using the PHQ-9 as a specific data point.

As a result of universal depression screening (PHQ-9) of around 5,000 patients, roughly half have met the criteria to benefit from a BH program. Of those 2,500 individuals, about 1,000 have participated in a BH program and shown improvement in their PHQ-9. The OSH care model, which takes a whole person approach to mental and physical health and relies on the collaborative care model, has proven to show a six to one return on investment. This has allowed OSH physicians and other clinicians to prioritize patient outcomes over the total number of visits. Optimal enrollment and member retention allow OSH to engage patients over time and know their total cost of care. Of over 25,000 eligible patients (based on model criteria), OSH has treated more than 6,000. OSH has also demonstrated decreases in utilization of emergency room and inpatient stays for this cohort. The goal of the program is to demonstrate a year-over-year reduction in medical costs similar to the study results. Thus far, OSH is on trend to reduce medical costs by year two of enrollment for patients in the behavioral health program.

A Case in Successful FFS Implementation

When Northwestern Medicine began the process to integrate behavioral health into primary care, they wanted to simplify workflow and add value throughout the process, all while ensuring their patients continued to be covered.

Focusing on simplicity for end users, they developed a smart form within the EHR to translate clinical information directly into billing for services. This form captures time spent with the patient and automatically allocates it to a payment code hierarchy, thereby simplifying the billing process and ensuring sustainability of the program.

Their experience with the automated billing and coding process, which has now been expanded to 11 clinics, has identified gaps in documentation prior to claim submission, enables the team to appropriately allocate resources, and ultimately ensures patients are receiving clinically appropriate care.

Moving Forward:

For access to tools available to help organizations review productivity and capacity and measure value, see the Resources section under Financial Planning.
Chapter 5: Assessing Readiness

Where to Start and Where You’re Headed

Think about where your practice is today and where you want to be in six months, a year, three years, etc. This chapter will help you understand what needs to happen today as well as the short- and long-term goals you may want to consider.

Reflect on Your Organization’s Mission

Once you’ve made the case for integration, consider the following:

- How does your mission align with integrated care?
- What are the current gaps that exist? How can they be filled now, and over time?
- What are the opportunities for improvement (training, workforce development)?
- How does integration align with other local and/or national efforts available to your practice such as patient-centered medical homes, state innovation model planning, etc.?

Evaluate Where You Are in the Process

An important step to assessing readiness is evaluating where you are in the process. Many practices and physicians are already taking steps and measures to incorporate behavioral health into their practice. For example, ask yourself:

- Do you currently promote mental wellness?
- Do you currently see patients with BH issues such as anxiety, depression, and/or substance use?
- Do you provide patients with BH issues with references or resources related to mental health and substance use?
- Do you routinely ask patients to fill out Patient Health Questionnaires, such as the PHQ-9, GAD-7, PHQ-2, EPDS, etc.?
- Do you have partnerships in place for timely referrals?

If you answered “yes” to any of these, you have already begun to integrate BH into your practice.

MOVING FORWARD:

There are various self-assessment tools available to help you better understand your practice’s readiness for implementation. For access to these tools, see the Resources section under Assessing Readiness.
Establishing metrics as a practice prior to implementation helps the team stay focused and contributes to clinician buy-in to continuing to measure progress. Including these metrics on the practice dashboard or scorecard confirms that these are some of the practice's most important priorities. Over time, you can use the "benchmarks" you've created to see how you're progressing and to adjust if the expected improvements are not realized.

Examples include the following:

- Increased use of screening instruments
- Earlier diagnosis
- Increased appropriate referrals to the behavioral health specialist
- Increased number of patients who were seen by specialists after referral was made
- Improved communication through increased face-to-face meetings or virtual exchanges to assess progress
- Improved medication adherence (prescriptions filled; pills taken)
- Decreased depression scores (e.g., PHQ-9 score over time)
- Fewer emergency visits
- Fewer hospital readmissions
- Enhanced well-being and quality of life for patients, caregivers, and care team
- More accurate financial projections through partnering or hiring and billing your own BH team

Tracking these metrics may require the use of technology not readily available to all small practices. A potential solution is for the practice to partner with a payer to track these metrics for them.

**TIP:**

Identify goals to track toward in the future, noting that it's important to know that not all metrics of success will be feasible for every practice to implement. For access to these tools, see the Resources section under Establishing Goals and Metrics of Success. While these tools are helpful in identifying goals to track toward, additional work is needed to help practices capture the specific data required to measure and assess such metrics.
Anatomy of the Team

In a physician-led team-based behavioral health model of care, the entire team—the primary care physician, behavioral health specialist, nurses, medical assistants, consulting psychiatrist, etc.—works together to provide collaborative care to patients.
It is important that everyone on the team has a good understanding of his or her role and the roles of others.

The list below includes examples of potential responsibilities that each care team member may have:

Primary care physicians:
- Talk to the patient/family and hear their concerns about BH
- Implement screening and monitoring tools for mental health disorders, make the diagnosis and/or determine the level of severity, initiate treatment, and manage medications
- Supervise the hands-on work of the behavioral health specialist and collaborate in frequent case conferences with the team to identify patient needs and opportunities for improvement

Medical assistants or nurses:
- Assess patients’ mental health needs by actively listening to patient responses and reviewing responses to screening questions on the pre-visit questionnaire
- Flag any concerning responses to the primary care physician and/or BH specialist

Behavioral health specialists/care coordinators:
- Participate in pre-clinic huddles; monitor symptom severity, treatment adherence, and side effects; report results to the primary care physician and/or the consulting psychiatrist
- Provide lifestyle counseling to address anxiety, depression, sleep disturbances, weight loss, exercise, and smoking cessation, and identify social-service needs
- Use motivational interviewing, problem-solving therapy, behavioral activation, and grief support
- For practices managing patients with addiction, behavioral health specialists can support patients’ addiction treatment, dosing, and recovery in consultation with the primary care physician
- For pediatrics specifically, participate in shared visits for children and youth, provide support to parents, communicate with childcare providers, teachers, and school guidance counselors
- Note: The BH specialist may be a psychologist, licensed social worker or nurse, or another individual trained in mental health/SUD, health education, or lifestyle counseling

Consulting psychiatrists:
- Assist with case conferences to review challenging cases of patients with behavioral health conditions
- Collaborate with the primary care physician and/or behavioral health care manager about diagnosis and treatment planning
- Support knowledge transfer to help primary care physicians understand how to care for people with mental health and substance use disorders
- Increase acumen of primary care team through means such as brief didactics and case review to improve not only the patient being discussed but also to better inform approaches to future patients who may present with similar issues and diagnoses
- Note: The psychiatrist is available to consult in-person or virtually with the behavioral health specialist and the primary care physician on the management of patients.

Establishing a Successful Partnership

Successful partnerships are characterized by effective collaboration, communication, and coordination between psychiatrists, BH specialists, primary care physicians and other clinicians, and the patient and patient’s family (where applicable). Continuing education, reminders, and training opportunities for team members, including the behavioral health specialist, nurses, and medical assistants, will help the care team continue to build their skill set and more fully apply their behavioral health knowledge in their daily interactions with patients.

CALLOUT:
For smaller practices or those in areas with limited resources, a behavioral health specialist could support the patients of multiple physicians and other clinicians within a practice and multiple practices, either through in-person appointments, physician consultation, or virtual appointments.

TIP:
The behavioral health specialist or psychiatrist may consult with the patient using telehealth; this may be a more cost-effective and feasible approach to offering behavioral health services than face-to-face visits.

WATCH OUT:
Responsibilities can be shared, divided, or moved, where appropriate, to less specialized health care workers to make more efficient use of the human resources available and quickly increase capacity through an approach known as task shifting. However, be aware that special considerations or limitations may exist when involving unionized health care workers.

MOVING FORWARD:
Identify team members, physicians, and other clinicians with whom to partner to better align your team. For a resource to help find regional resources near you, see the Resources section under Aligning the Team.
Part 4: Implementation
Example of a Suggested Workflow for a Small Private Practice

The workflow illustrated below assumes that the practice has already established external relationships with other specialties and that they have aligned on and coordinated BH efforts. As noted previously, different roles may take on different responsibilities throughout the workflow.

| Confirmation of Eligibility and Benefits | Prior to the patient visit, eligibility is verified, and patient benefits are confirmed |
| Patient Arrives for Scheduled Appointment | Patient presents with chief complaint(s) and medical assistant asks patient/family about any BH concerns |
| Screening for BH | BH screening performed (incorporated as a part of the office visit) |
| BH Positive Indication | Positive screen (indicating depression, substance use, etc.) |
| Discussion with Patient | Physician discusses the diagnosis/status with the patient and/or caregivers and recommends BH services and treatment |
| BH Coordination and Collaboration of Care | Care manager meets with the patient and collaborates with treating practitioners for the episode of care (based on severity and risk). If applicable, care manager provides patient education about available resources |
| Care Oversight | Physician continues to oversee the patient’s care, including prescribing medications, treating medical conditions, and making referrals to specialty care |

Establishing Partnerships Outside the Practice

Assessing the capabilities and availability of additional supportive services in the surrounding community can be just as important as preparing the practice for integration. Apply a “population” perspective to gain understanding of the behavioral health needs of children, youth, and adults in the community. This could be as simple as incorporating discussion into a weekly team meeting or huddle.

Take steps to:

- Inventory community mental health and addiction resources
- Develop or strengthen relationships with mental health advocates, schools, human service agencies, mental health and substance use treatment specialists, and developmental specialists
- Collaborate on system-focused initiatives such as filling gaps in needed services and care coordination and developing community protocols for managing psychiatric emergencies and overdoses
- Address stigma by discussing it openly throughout the workflow

Preparation for and Designing an Updated Workflow

When a patient requires a behavioral health intervention, the team must have an explicit pathway to follow to decide: Should the patient be assessed that day? Are they at risk of harming themselves or others? Do they need a full consult with a psychiatrist or BH specialist? Create processes and protocols for the entire care team to recognize their roles and when the behavioral health specialist should become involved. Also, ensure each team member knows which aspects of patient follow-up are their responsibility and which belong to the behavioral health specialist. This should be reflected in shared practice protocols under the physician’s leadership.

Practice Spotlight

A Case of Successful Implementation into Workflow

An ob-gyn practice in Massachusetts recognized mental health as a critical component of quality perinatal care and sought to integrate mental health screening, assessment, intervention, referral, and follow up into their practice workflow.

To do so, they enrolled in the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms program. MCPAP for Moms delivers evidence-based trainings and toolkits with guidance on how to screen, assess, and treat mental health conditions in perinatal care settings. In addition, MCPAP for Moms’ team of psychiatrists, who have expertise in perinatal mental health, provides consultation to physicians and other clinicians.

Soon after the practice participated in training and integrated these processes into their workflow, a patient presented for care and screened positive for depression at 14 weeks gestational age. The practice called MCPAP for Moms’ team of psychiatrists, who have expertise in perinatal mental health, provides consultation to physicians and other clinicians.

The ob-gyn was further equipped to consult, the ob-gyn was further equipped to discuss treatment options, connect the patient to a therapist, and prescribe an antidepressant.
Training Members of the Primary Care Team

A primary care physician, psychiatrist, and/or BH specialist should take the lead in determining the skills that should be acquired by the end of the training process. Examples of important skills include being able to engage patients in a manner that is supportive and non-judgmental, being well-versed in active listening, being at ease using positive, person-first language, managing stressful encounters with a positive attitude, and speaking to cultural differences between clinicians to help ease the transition to integrated care.

Online and in-person training is available through many different organizations. Practices should choose the programs they implement based on skills that their staff needs to develop further. Review of training offerings can also help when taking inventory of current team members’ skills and deciding which skills need to be recruited for.

Implementing Team-based Behavioral Health Integration

Know how and when to perform mental health assessments:

- Team members who will be conducting pre-visit planning and rooming patients should be trained on how to perform a mental health screening using a validated questionnaire, such as the Patient Health Questionnaire-2 (PHQ-2) and/or the Patient Health Questionnaire-9 (PHQ-9)xxi,xxii
- Events such as a death in the family, job loss, a recent disease diagnosis (for the patient, a partner, family member, or friend), proximity to domestic abuse, or a history of mental health conditions should prompt a behavioral health assessment and, potentially, a behavioral health referral. For a patient who is experiencing one or more of these stressors, the front-line clinician may recommend that the behavioral health specialist become involved in the patient’s care

Steps for preparing the team include:

- Identify staff leaders who will champion the effort, be accountable for the integration and training processes, and share plans of care across systems
- Develop (or procure) written and/or video training materials (scripts, guides, reference documents) for staff
- Schedule group training session(s)
- Plan for how and when training will be refreshed/reviewed
- Communicate with the team on a regular basis

Help the patient and family/caregiver understand why a behavioral health assessment is being recommended, using phrases such as “In taking care of people experiencing situations like yours, we have found that they do better and feel better sooner using this approach” and explaining the roles of various team members involved in their care. This is a good time to reassure them that behavioral health assessment and care are provided “in addition to” their usual care.

TIP:

Health coach training could help your team develop the skills they need to educate your patients more effectively about lifestyle and behavioral issues. Training curricula often teach strategies for patient engagement, motivational interviewing, and creating an action plan with patients/caregivers.

Steps to Prepare the Care Team

Successful integration of BH requires buy-in from all members of the care team. Success depends on a shared commitment to training on best practices for delivering care, implementation of new workflow procedures, and understanding and use of patient-focused engagement materials (see Integration Training Resources in the Resources section).

Steps for preparing the team include:

- Identify staff leaders who will champion the effort, be accountable for the integration and training processes, and share plans of care across systems
- Develop (or procure) written and/or video training materials (scripts, guides, reference documents) for staff
- Schedule group training session(s)
- Plan for how and when training will be refreshed/reviewed
- Communicate with the team on a regular basis

MOVING FORWARD:

For additional information regarding training resources, see the Resources section under Preparing the Clinical Team.
Engaging Patients and Caregivers

It is important that care teams explain the “why and how” of integrated care to patients and family/caregivers by:

- Triaging patients to the appropriate level of care while managing the patient’s needs in the interim
- Using appropriate and helpful language to introduce BH physicians and other clinicians in ways that help address the patient’s confusion or fears about their situation or meeting someone new
- Offering hopeful, encouraging, understanding, reassuring, and acknowledging comments and avoiding dismissive or blaming comments
- Educating patients about their clinical situation and care, involving parents, families, guardians, or caregivers as appropriate to age, developmental stage, and circumstance (for more information on promoting social-emotional health among young children and teens)
- Describing the screening process and explaining the results
- Helping patients understand the commitment of the primary care team and behavioral health specialists to whole person care and address any concerns they may have with their care or barriers to receiving it

Best Practices to Partner with the Patient

In order to create a comfortable environment for the patient, consider the following:

- **Start Early:** Let your patients (and/or their parent(s)/caregiver(s)) know early in the relationship of the importance of addressing both physical and mental health. Let patients/caregivers know they should feel free to bring up any questions or problems during visits
- **Look Out for the Red Flags and Risk Factors:** Understand and look for the warning signs of mental illness and substance use, listen to patient and caregiver concerns, and connect them to mental health specialists and specific resources. Additionally, understand risk factors for children and families in regard to caregiver health and well-being, social determinants of health, and risks for toxic stress. Follow up with the patient and initiate warm handoffs with the care manager if needed
- **Directly Involve the Patient in Their Care:** Educate the patient along with the family (if appropriate) about what to expect, including why certain assessments are performed. Encourage them to describe how they are feeling as compared to prior visits and to share any concerns they may have about potential medication side effects
- **Focus on Destigmatization:** When having conversations, make sure to use non-stigmatizing language that is appropriate for the patient’s background. Certain groups, such as older patients and certain cultural groups, view mental and behavioral health care as taboo. As an example, framing conversations based on symptoms rather than illness (feeling bad or down instead of depressed, feeling scared or worried instead of anxiety) may help
- **Provide Resources:** Make resources available in waiting rooms and exam rooms. These could be fact sheets, guides, pamphlets, and/or brochures about behavioral health and local support groups and services. Seeing these resources may give your patient the nudge they need to raise concerns

Focus on Destigmatization:

- When utilizing this method, follow the “RULE” approach:
- **Resist** telling the patient what to do. Avoid telling, directing, or convincing them what a “right” path may be
- **Understand** their motivation: Gain an understanding of their values, needs, abilities, motivations, and potential barriers to changing behaviors
- **Listen** with empathy: Offer understanding and support for their values, needs, abilities, motivation, and potential barriers to changing behaviors
- **Empower** them: Work with the patient to set achievable goals and identify techniques to overcome barriers

MOVING FORWARD:

To learn how to best interact with various patient populations visit the Resources section under Partnering with the Patient.
Chapter 11: Financial Sustainability: Billing and Coding

There is no one-size-fits-all financial model for BHI. Many practices primarily support their BHI efforts through fee-for-service (FFS) billing alone, utilizing relevant BHI codes and working directly with their local commercial health plans or self-insured employers. Some practices leverage their participation in alternative payment models (APMs) (or other value-based care contracts) to support their behavioral health integration efforts.

There are many payment models to consider in addition to FFS, and no matter which you choose, the ultimate goal is sustainable delivery of high-quality care.

BHI Billing Under Medicare

Medicare pays for integrated BHI services provided to patients, including assessments, monitoring, and care planning performed by clinical staff, as well as psychiatric collaborative care services.

BHI Billing Under Medicaid

Medicaid is the single largest payer for mental health services in the United States and is increasingly playing a larger role in the reimbursement of substance use disorder services. The Centers for Medicare & Medicaid Services are responsible for implementing laws passed by Congress related to Medicaid, and the Medicaid program is funded by both the federal and state governments. The joint funding models allow each state the option to charge premiums and/or develop cost sharing. Providers considering enrolling in Medicaid should visit their state Medicaid website to understand requirements for Medicaid enrollees.

Cost sharing or out-of-pocket payments due from the Medicaid enrollee directly impact the practice. The cost share or out-of-pocket amount the Medicaid enrollee is required to pay is a copay, coinsurance, deductible, or other similar charge. These amounts may vary based on the Medicaid recipient’s income, may require month-to-month collection based on Medicaid eligibility, or may require reporting the amount collected to the Medicaid program prior to claim payment. Medicaid premiums and cost-sharing requirements differ by state, so check your state Medicaid program requirements for specific details.

BHI Billing for Commercial Payers

It is important for a practice/system to establish a direct line of communication with their contracted health plans and large, self-insured employers in their community to understand and align on goals around the provision of and payment for BHI. Behavioral health is a stated priority for many health plans and large employers, and they should welcome, and even support, a dialogue with practices on the provision of enhanced behavioral health services to their beneficiaries and employees.

TIP:

As many health plans and insurers are encouraging models of care that incorporate the use of a consulting psychiatrist and warm handoffs, confering with them on appropriate coding may help prevent a patient from being charged multiple copays. For the patient who is anxious about finances, receiving one bill for the primary care visit and another, possibly higher bill for specialist care may exacerbate their mental health condition.

WATCH OUT:

Chronic Care Management (CCM) and BHI are separate but can be confused with each other when billing. It is very important to distinguish between the two:

- CCM involves care planning for all health issues
- BHI involves care planning that focuses on individuals with behavioral health issues and systematic care management using validated rating scales (when applicable) and does not focus on preventive services

CALLOUT:

The Medicare BHI codes are not limited to beneficiaries with certain behavioral health conditions; codes may be used to treat patients with any behavioral health condition (e.g., anxiety, depression, insomnia). Payment for these services requires that there be a presenting mental, psychiatric, or behavioral health condition(s) that in the clinical judgment of the billing practitioner warrants BHI services. The diagnosis or diagnoses could be either pre-existing or first made by the billing practitioner and may be refined over time.
Relevant Codes

The following are various Current Procedural Terminology (CPT®)/HCPCS codes relevant to BHI. While this list is not exhaustive, it can serve as an initial starting point:

**Counseling Risk Factor Reduction and Behavior Change Intervention**
- Preventive Medicine
  - 99401, 99402, 99403, 99404 (Individual)
  - 99411, 99412 (Group)
- Behavior Change Interventions
  - 99406-99407 Smoking and tobacco use cessation counseling visit
  - 99408-99409 Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention (SBI) services

**Psychotherapy**
- 90832, 90834, 90837 Psychotherapy (30, 45, 60 min)
- 90833, 90836, 90838 Psychotherapy when performed with E/M service
- 90835 Group Psychotherapy

**Developmental/Behavioral screening**
- 96127 Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
- 96110 Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument
- 96161 Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

**Adaptive Behavior Services**
- Address deficient adaptive behaviors, maladaptive behaviors, or other impaired functioning secondary to deficient adaptive or maladaptive behaviors (e.g., instruction-following, verbal and nonverbal communication, imitation, play and leisure, social interactions, self-care, daily living, personal safety)
  - 97151, 97152 (Assessment)
  - 97153-97158 (Treatment)

**Health Behavior Assessment and Intervention**
- Focus on psychological, behavioral, emotional, cognitive, and interpersonal factors, and factors complicating medical conditions and treatments
  - 96156-96171 (Individual, Group, Family)

**Care Management**
- 99484 General Behavioral Health Integration Care Management
- 99492-99494 Psychiatric Collaborative Care Management

**Inter-professional Digital Services**
- 99446-9, 99451 Professional-to-professional digital consultation, billable by the consulting psychiatrist
- 99452 Professional-to-professional digital consultation, billable by the primary care professional

**Cognitive Assessment and Care Plan Services**
- 99483
- Provided when a comprehensive evaluation of a new or existing patient, who exhibits signs and/or symptoms of cognitive impairment, is required to establish or confirm a diagnosis, etiology, and severity for the condition
- Thorough evaluation of medical and psychosocial factors, potentially contributing to increased morbidity

**TIP:**
For viability and sustainability, intermittent joint meetings may also be held to assess accounts receivable, payers paying or not paying, collection of copays, and codes submitted for whether or not they are being paid.
Chapter 12: Measuring Progress

Behavioral health integration is a constantly evolving process.

As such, it is important to measure practice performance and progress on goals at regular intervals and to modify your approach when needed.

Measuring Value in Integrated Care Models

Value can be measured in a variety of ways, including but not limited to:

- **Productivity:** Increased access to behavioral health services, which can drive primary care physician efficiency
- **Health outcomes:** Improved patient health outcomes, including meeting quality measures, is consistent with successful integration
- **Patient, family/caregivers, and care team satisfaction:** Providing proactive, quality care to meet the patients' needs improves satisfaction
- **Engagement:** With a diverse skill set due to BHI training, behavioral health specialists can, and should, provide multiple kinds of visits such as helping patients with self-care, individual or group treatment, “warm handoffs” or other introductory visits, and group sessions to promote engagement

Knowing the Milestones of Progress

Being able to recognize successful integration of BH in your practice is important. While often different for each practice, successful organizations are those who are able to:

- Advocate for a mission and vision focused on integrated care
- Build a sustainable staffing structure for integrated care
- Create a team-based culture
- Structure the organization for delivering integrated care
- Optimize physical workspace for providing integrated care
- Organize health information technology to support integrated care
- Manage the structure and timing of integrated care delivery
- Utilize communication tools and practices that facilitate integrated care
- Utilize clinical practices of integrated care teams

**TIP:**

Behavioral health team updates should be on the agenda at regular team meetings. This gives the entire team the opportunity to evaluate team progress, explore ways to collectively make processes better, increase and improve communication, and keep the focus on providing the best care to patients.

**MOVING FORWARD:**

For additional information regarding benchmarking and established tools to measure success, see the Resources section under Measuring Progress.
### PART 2: BHI BASICS AND BACKGROUND

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### PART 3: GETTING STARTED

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### PART 3: RESOURCES & TOOLS

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<td>The Six Levels of Collaboration/Integration</td>
<td>The six levels of collaboration/integration are organized by Coordinated, Co-Located, and Coordinated in this table. The core description, key differentiators, strengths, and weaknesses of each level are explained.</td>
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<tr>
<td>CoCM Information and Details</td>
<td>This website provides further information and detail on the CoCM specifically, including free training.</td>
<td>American Psychiatric Association (APA)</td>
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<tr>
<td>SBI RT Model of Care</td>
<td>For more information on the Screening, Brief intervention, and Referral to Treatment (SBIRT) model of care, this change guide assists primary care physicians and other clinicians in integrating care for patients with unhealthy alcohol and/or drug use into routine medical care.</td>
<td>National Council for Behavioral Health</td>
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<tr>
<td>A List of Resources by Focus Area</td>
<td>This website contains multiple resources related to BHI, organized by Assessing Organizational Readiness, Building the Business Case, and Workforce Development.</td>
<td>SAMHSA+RSA Center of Excellence for Integrated Health Solutions</td>
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<tr>
<td>Perinatal Mental Health State-Based Model</td>
<td>This website describes MCPAP for Moms, a state-based model that provides training, psychiatric consultation, and referrals to care for obstetric, pediatric, primary care, and psychiatric providers serving pregnant and postpartum patients.</td>
<td>Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms)</td>
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<td>Child Psychiatry Access Programs</td>
<td>Access this site for information on child psychiatry access programs across the nation.</td>
<td>National Network of Child Psychiatry Access Programs</td>
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<td>Maternal and Child Health Initiative</td>
<td>Reference this site for information on the Maternal and Child Health Bureau, which aims to promote mental health and well-being in these two populations.</td>
<td>Health Resources &amp; Services Administration Maternal and Child Health</td>
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<td>Primary Care Innovations and PCMH Map by State</td>
<td>Utilize the map available on this site for brief descriptions of PCMH's activity across each state.</td>
<td>Primary Care Collaborative</td>
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## PART 3: GETTING STARTED

### Chapter 5: Assessing Readiness
- **Title:** Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration: Two Major Self-Assessment Tools
  - **Description:** Access this PDF to utilize two major self-assessment tools: The Partnership Checklist and the Executive Walkthrough.
  - **Organization:** SAMHSA-HRSA Center for Integrated Health Solutions

- **Title:** Mental Health Practice Readiness Inventory
  - **Description:** Access this PDF to determine level of readiness and identify areas where your practice may need to focus efforts.
  - **Organization:** American Academy of Pediatrics (AAP)
  - **Link:** [https://www.aap.org/sites/default/files/resources/MeHAF-Facilitation-Guide-Tool_190128.pdf](https://www.aap.org/sites/default/files/resources/MeHAF-Facilitation-Guide-Tool_190128.pdf)

- **Title:** Maine Health Access Foundation (MeHAF) Site Self-Assessment Survey Facilitation Guide
  - **Description:** Reference this document for further information on incorporating telehealth into your practice.
  - **Organization:** American Medical Association (AMA)
  - **Link:** [https://waportal.org/sites/default/files/resources/Facilitation-Guide-Tool_190128.pdf](https://waportal.org/sites/default/files/resources/Facilitation-Guide-Tool_190128.pdf)

### Chapter 6: Establishing Goals and Metrics of Success
- **Title:** Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration: Two Major Benchmarking Tools
  - **Description:** Access this PDF to utilize two major benchmarking tools: The Administrative Readiness Tool (ART) for Primary Health Behavioral Health Integration and the COMPASS-Primary Health and Behavioral Health.
  - **Organization:** SAMHSA-HRSA Center for Integrated Health Solutions

- **Title:** Behavioral Health and Substance Use Quality Measures
  - **Description:** Visit this site for information on the Quality Forum's portfolio of behavioral health measures for practices to track towards.
  - **Organization:** National Quality Forum
  - **Link:** [http://www.qualityforum.org/ProjectDefinition.aspx?ProjectID=86014](http://www.qualityforum.org/ProjectDefinition.aspx?ProjectID=86014)

### Chapter 7: Aligning the Team
- **Title:** Identifying Local Resources
  - **Description:** Through FindHelp.org, information regarding locating and accessing local behavioral health resources is provided by entering only a ZIP code or location.
  - **Organization:** findhelp.org
  - **Link:** [https://www.findhelp.org/](https://www.findhelp.org/)

## PART 4: IMPLEMENTATION

### Chapter 8: Designing Workflow
- **Title:** Team Building & Workflow Guide
  - **Description:** This document can be used to help guide you through the workflow and align on a plan.
  - **Organization:** Advanced Integrated Mental Health Solutions (AIMS) Center
  - **Link:** [https://www.aims.uw.edu/sites/default/files/EDM/Advanced_ Integrated_Mental_Health_Practice_Workflows_2.pdf](https://www.aims.uw.edu/sites/default/files/EDM/Advanced_Integrated_Mental_Health_Practice_Workflows_2.pdf)

- **Title:** A Process for Integrating Mental Health Care into Pediatric Practice
  - **Description:** For examples of various workflows in pediatrics, see this document.
  - **Organization:** American Academy of Pediatrics (AAP)
  - **Link:** [https://downloads.aap.org/AAP/PDF/Mental_Health_Services.PDF](https://downloads.aap.org/AAP/PDF/Mental_Health_Services.PDF)

### Chapter 9: Preparing the Clinical Team
- **Title:** The Partnership Checklist
  - **Description:** Utilize this Partnership Checklist to determine if a partnership is necessary to achieve the desired outcomes for the integration program in your practice or organization.
  - **Organization:** SAMHSA-HRSA Center of Excellence for Integrated Health Solutions
  - **Link:** [https://www.samhsa.gov/EndHelp/national-helpline](https://www.samhsa.gov/EndHelp/national-helpline)

- **Title:** Resources for Mental Health Services
  - **Description:** This PDF contains further resources for key mental health services.
  - **Organization:** American Academy of Pediatrics (AAP)
  - **Link:** [https://downloads.aap.org/AAP/PDF/Source_of_Key_Mental_Health_Services.pdf](https://downloads.aap.org/AAP/PDF/Source_of_Key_Mental_Health_Services.pdf)

- **Title:** Maternal Mental Health National Resource
  - **Description:** Medical providers who treat pregnant and postpartum patients can use PSI's Perinatal Psychiatric Consult Line for questions about mental health care.
  - **Organization:** Lifeline4Moms
  - **Link:** [https://www.unravelmed.edu/lifeline4moms/Access-Programs/network-members-us/](https://www.unravelmed.edu/lifeline4moms/Access-Programs/network-members-us/)

- **Title:** Maternal Mental Health State Resources
  - **Description:** Perinatal Psychiatry Access Programs support providers in assessment and treatment of perinatal mental health conditions. For a list by state, visit this website.
  - **Organization:** Perinatal Support International
  - **Link:** [https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/](https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/)

- **Title:** Identifying National Resources
  - **Description:** This link contains additional resources and helplines available to physicians and patients.
  - **Organization:** Substance Abuse and Mental Health Services Administration (SAMHSA)
  - **Link:** [https://www.samhsa.gov/EndHelp](https://www.samhsa.gov/EndHelp)
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<td>Billing, Workflow, and Administrative Tools for Successful Implementation of CoCM</td>
<td>Chapter 12: Part 2: Measuring Progress</td>
<td>Watch this CIHS and SAMHSA-HRSA Webinar on the use of benchmarking for information on how benchmarking can drive successful behavioral and primary care integration.</td>
<td>SAMHSA-HRSA Center for Integrated Health Solutions</td>
<td><a href="https://www.youtube.com/watch?v=YogOTc5M1Vs">https://www.youtube.com/watch?v=YogOTc5M1Vs</a></td>
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